

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 10 August 2006

Case No. 2004-BLA-6064

In the Matter of:

T.S.,¹

Claimant,

v.

CARTER BRANCH MINING CO.,

Employer,

and

OLD REPUBLIC INSURANCE,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS'

COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:

Joseph E. Wolfe, Esq.

On behalf of Claimant

Lois A. Kitts, Esq.

On behalf of Employer

BEFORE: THOMAS F. PHALEN, JR.
 Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

¹ The Department of Labor has directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site starting prospectively on August 1, 2006, and to insert initials of such claimant/parties in the place of those proper names. This order only applies to cases arising under the Black Lung Benefits Act, the Longshore and Harbor Workers' Compensation Act, and FECA. In support of this policy change, DOL has directed submission of a proposed rule change to 20 C.F.R. § 725.477, proposing the omission of the requirement that decisions and orders of Administrative Law Judges contain the claimant/parties' initials only, to avoid unwanted publicity of those claimants on the web, and has installed software that prevents entry of the full names of claimant parties on final decisions and related orders. I strongly object to that policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank*, 951 F. 2d 320 (11th Cir. 1992) and

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, (“the Act”) and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.²

On March 29, 2004, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers’ Compensation Programs, for a hearing. (DX 32).³ A formal hearing on this matter was conducted on February 22, 2006, in Pikeville, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES⁴

The issues in this case are:

1. Whether the claim was timely filed;
2. Whether the Miner has pneumoconiosis as defined by the Act;
3. Whether the Miner’s pneumoconiosis arose out of coal mine employment;
4. Whether the Miner is totally disabled;
5. Whether the Miner’s disability is due to pneumoconiosis;
6. Whether the named employer is the Responsible Operator; and

those collected at 27 Fed. Proc., L. Ed. § 62:102 (Thomson/West July 2005). Furthermore, I strongly object to the specific direction by the DOL that Administrative Law Judges have a “mind-set” to use the complainant/ parties’ initials if the document will appear on the DOL’s website, for the reason, *inter alia*, that this is not a mere procedural change, but is a “substantive” procedural change, reflecting decades of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge’s decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial “mind-set” constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

² The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

³ In this Decision, “DX” refers to the Director’s Exhibits, “EX” refers to the Employer’s Exhibits, and “CX” refers to the Claimant’s Exhibits.

⁴ While not discussed on the record, the parties stipulated to at least 20 years of coal mine employment and initialed a copy of DX 32, which I have identified as ALJ 2 for identification purposes. Additionally, Employer listed other issues that will not be decided by the undersigned; however, they are preserved for appeal. (DX 32, Item 18).

7. Whether the named employer has secured the payment of benefits.

(DX 32).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

T.S. ("Claimant") was born on September 2, 1946, and was 59 years old at the time of the hearing. (DX 2, 16; Tr. 34). He completed the eighth grade. (DX 2). Claimant also served in the military in 1967 and 1968. (Tr. 32). On May 2, 1970, Claimant married G.S.S., but they divorced in August 1989. (DX 2, 8). He stated that he does not pay his former wife any sort of support. (DX 2, 16; Tr. 32). On December 7, 1990, Claimant married M.A.D, and they remain married. (DX 2, 7; Tr. 32). He has no dependent children. (DX 2, 16; Tr. 32). Employer concedes, and I so find, that Claimant has one dependent for purposes of augmentation. (DX 32).

On his application for benefits, Claimant stated that he engaged in coal mine employment for at least 25 years. (DX 2). Claimant's last coal mine employment was as a general inside coal worker and roof bolter. (DX 4). Claimant described the physical requirements of the work to include working on his knees and in squatting positions, and lifting and carrying as much as 60 pounds. (DX 4). Claimant stated that he last worked in and around coal mines in 1993, when he quit due to an injury. (DX 2, 16; Tr. 31). He also noted on his application that he has not previously filed a federal pneumoconiosis disability claim, but he received a payment for his 1995 Workers' Compensation claim. (DX 2, 6).

Procedural History

Claimant filed a claim for benefits under the Act on November 27, 2002. (DX 2). On December 3, 2003, the District Director, Office of Workers' Compensation, issued a proposed decision and order – award of benefits. (DX 25). On December 12, 2003, Employer requested a formal hearing. (DX 27). On March 29, 2004, this matter was transferred to the Office of Administrative Law Judges. (DX 32).

Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001).

Employer continues to contest the timeliness of this claim. (DX 32). However, employer has offered no proof as to why it believes this claim to be untimely. In fact, at the deposition, Claimant testified that no doctor has ever told him that was totally disabled because of black lung. (DX 16). As the record includes no medical reports submitted more than three years prior to the filing of this claim, I find that Claimant's claim is timely pursuant to the presumption found at § 725.308(c).

Length of Coal Mine Employment

On his application, Claimant stated that he engaged in coal mine employment for at least 25 years. (DX 2). At the deposition, however, Claimant stated that he worked in coal mining for more than 20 years (DX 16), and at the hearing, he testified to at least 22 years (Tr. 31). The Director determined that Claimant has at least 24 years of coal mine employment. (DX 25). The parties, however, stipulate that Claimant worked at least 20 years in or around one or more coal mines. (ALJ 2). I find that the record supports this stipulation, (DX 2-5), and therefore, I hold that the Claimant worked at least 20 years in or around one or more coal mines.

Claimant's last employment was in the Commonwealth of Kentucky (DX 2, 16); therefore, the law of the Sixth Circuit is controlling.⁵

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. Claimant testified that his last employer was Carter Branch Mining, and that he worked there from approximately 13 years. (DX 16; Tr. 35). The District Director identified Carter Branch Mining Co., Inc. as the putative responsible operator due to the fact that it was the last company to employ Claimant for a full year. (DX 17, 25). Furthermore, Employer has presented no evidence to contradict the Director's finding, and since Employer has failed to address this issue in a post-hearing brief, I find that Carter Branch Mining Co., Inc. is properly designated as the responsible operator in this case.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing

⁵ Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

The record in this matter was held open post-hearing. The parties were given until April 22, 2006 to submit additional medical evidence. (Tr. 50). Employer was to submit supplemental reports by Drs. Fino and Rosenberg, and Claimant was to submit to Employer the March 19, 2005 x-ray for a rebuttal reading. (Tr. 48-49). The parties were then given until May 22, 2006 to submit rebuttal evidence and revised evidence summary charts, and June 22, 2006 to file post-hearing briefs. (Tr. 50-51).

On March 30, 2006 and April 17, 2006, Employer submitted supplemental medical reports by Drs. Rosenberg and Fino. On May 22, 2006, Employer submitted an updated evidence summary form. This submission included an objection to Claimant's interpretation of the March 19, 2005 film by Dr. DePonte, since Claimant had failed to submit the film for a rebuttal reading. As a result, Employer moved that this reading be removed from consideration. Based on eventual receipt of the March 2005 film, on June 8, 2006, Employer motioned to re-open the record and for an extension to file a post-hearing brief. On June 20, 2006, Claimant submitted his post-hearing brief. Finally, on June 26, 2006, Employer submitted Dr. Wheeler's interpretation of the March 2005 x-ray.

Drs. Rosenberg and Fino's supplemental medical reports are admitted into the record and will be designated as EX 15 and EX 16, respectively. Employer's updated summary form is admitted into the record and will be designated as EX 14. Due to the fact that Claimant did not submit the March 19, 2005 x-ray to Employer for rebuttal interpretation until more than one month after the established deadline, Employer's May 22, 2006 objection is sustained, and Dr. DePonte's interpretation of this film will not be considered in the instant adjudication. As a result, Employer's June 8, 2006 motions are denied, and thus, Dr. Wheeler's interpretation of the March 19, 2005 film is not admitted into the record.⁶

⁶ Considering the difficulties experienced at hearing, I am astonished by the parties' failure to follow through with the post-hearing instructions. While Claimant was not required to file evidence to rebut Employer's post-hearing submissions, his failure to timely submit the March 2005 x-ray has placed the undersigned in a position where fairness requires that Claimant's otherwise admissible and probative evidence be excluded from consideration. In addition, Claimant's failure to submit a supplemental evidence summary form, despite the obvious errors in its initial form, requires that the undersigned sort through the brief and hearing transcript in order to determine which of Claimant's evidence remains admissible. On the other hand, Employer has not submitted a post-hearing brief, presumably in reliance on its supplemental motion for inclusion of late evidence and an extended briefing schedule. Employer's reliance was unfounded. If Employer wished to brief this matter it should have abided by the post hearing schedule. The hearing was held on February 22, 2006. Holding the record open until June 22, 2006 placed this case at 120 days before I could even consider the matter. Employer's request for an additional 30 days, notwithstanding any additional Claimant requests for rebuttal, would have stretched the matter to 150 days. I find such further delay to be inappropriate. Therefore, Employer's extension requests are denied and the record was closed as of June 22, 2006.

Claimant selected the Randolph Forehand to provide his Department of Labor sponsored complete pulmonary examination. (DX 9). The examination was conducted on December 12, 2002. I admit Dr. Forehand's report under § 725.406(b). I also admit Dr. Barrett's quality-only interpretation of the x-ray and Dr. Burki's validation of the ABG under § 725.406(c).

Claimant completed a Black Lung Benefits Act Evidence Summary Form, but he did not update this report as directed by the undersigned. (Tr. 16, 50). Considering the February 2, 2006 chart, I note that Claimant designated Dr. Rasmussen's October 28, 2003 PFT, ABG, and medical report as initial evidence, but at the hearing, he specifically withdrew these reports from consideration in this matter. (Tr. 15). Therefore, I find that Dr. Rasmussen's October 2003 report will not be considered in the resolution of this claim. Likewise, since Claimant did not submit the March 19, 2005 film to Employer for an opportunity to rebut, as stated above, Dr. DePonte's interpretation of this film will not be considered in the instant adjudication. On the other hand, I find that Claimant's remaining evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(3), and is therefore admitted into evidence. This includes: x-ray interpretations by Dr. Rasmussen (5/5/05 film), DePonte (10/27/03 film), and Alexander (12/12/02 film), and Dr. Rasmussen's May 5, 2005 PFT and medical report. Also, even though Claimant did not designate Dr. Rasmussen's ABG study, since this evidence was considered in reaching his disability finding, and since Claimant has not otherwise designated any additional ABG evidence I find "good cause" to consider the results of this study.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (EX 14). Employer designated Dr. Rosenberg's October 27, 2003 X-ray interpretation, PFT, and ABG, his January 26, 2006 medical report, and his March 13, 2006 supplemental report as initial evidence. Employer also designated Dr. Fino's January 27, 2006 report, his February 13, 2006 deposition, and his April 7, 2006 supplemental report as initial evidence. Next, Employer designated Dr. Caffrey's May 27, 2005 report as biopsy evidence, Dr. Wheeler's interpretation of the October 27, 2003 x-ray, Dr. Wheeler's February 8, 2005, January 31, 2005, March 21, 2005, and December 9, 2004 CT scan interpretations, and his supporting deposition as initial evidence. Employer also submitted treatment records from Hunting VAMC, Buchanan General Hospital, Carilion Roanoke Memorial Hospital, and Bristol Regional Medical Center. In rebuttal, Employer designated Dr. Wheeler's interpretation of the May 5, 2005 x-ray and Dr. Wiot's interpretation of the December 12, 2002 x-rays. This evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, I admit the above designated evidence.

Attached to Employer's evidence summary form was a sheet that listed Drs. Rosenberg and Fino's interpretations of four CT scans. However, since Employer had designated Dr. Wheeler's interpretations of these scans, consideration of additional interpretations would exceed the limitations of §725.414. *See Webber v. Peabody Coal Co*, 23 B.L.R. 1-___, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc) (J. Boggs, concurring)(the Board held "only one reading or interpretation of each CT scan or other medical test or procedure [may] be submitted as affirmative evidence"). While the list states that these interpretations are "to be considered under [the] good cause exception, Employer does not provide any rationale for inclusion of this

duplicative evidence.⁷ Therefore, I find that the CT scan interpretations by Drs. Rosenberg and Fino are redundant, and thus, that “good cause” does not exist for their consideration in the instant adjudication.

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
DX 10	12/12/02	12/12/02	Forehand, B-reader ⁸	1/1 ps
DX 11	12/12/02	01/03/02	Barrett, BCR ⁹ , B-reader	Quality only
DX 12	12/12/02	08/25/03	Alexander, BCR, B-reader	2/2 pt
EX 13	12/12/02	09/30/03	Wiot, BCR, B-reader	Negative
EX 1	10/27/03	10/27/03	Rosenberg, B-reader	Negative
CX 3	10/27/03	09/20/04	DePonte, BCR, B-reader	1/0 ps; Category A
EX 7	10/27/03	06/02/05	Wheeler, BCR, B-reader	Negative
CX 1	05/05/05	05/06/05	Rasmussen, B-reader	1/2 tr; Category A
EX 8	05/05/05	06/27/05	Wheeler, BCR, B-reader	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height¹⁰	FEV₁	FVC	MVV	FEV₁/ FVC	Qualifying Results
DX 10 12/12/02	Good/ Good/ Yes	56 69”	3.33	3.97	110	84	No
EX 1 10/27/03	Good/ Good/ Yes	57 70”	2.58 2.80*	3.09 3.22*	87 102*	84 87*	No No*
CX 1 5/5/05	Not listed/ Not listed/ Yes	58 69”	2.21 2.26*	2.71 2.73*		81 83*	No No*

*indicates post-bronchodilator values

⁷ Dr. Fino’s deposition provides some convincing rationale for inclusion of his CT scan interpretations in excess of the limitations, but I note that Employer chose to designate Dr. Wheeler’s interpretations instead of Dr. Fino’s readings, presumably due to Dr. Wheeler’s more advanced credentials. (EX 5). Therefore, I find that Dr. Fino’s arguments are not sufficient to justify their inclusion in evidence.

⁸ A “B” reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.51) Consequently, greater weight is given to a diagnosis by a “B” Reader. See *Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

⁹ A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. See 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

¹⁰ The factfinder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find Claimant’s height to be 69.33 inches.

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO₂	pO₂	Qualifying
DX 10	12/12/02	32 37*	70 63*	No ¹¹ Yes*
EX 1	10/27/03	34.4	86.7	No
CX 1	05/05/05	35	71	No

* indicates post-exercise values

Biopsy Evidence

Dr. Raphael Caffrey submitted a biopsy report dated May 27, 2005. (EX 6). On microscopic examination of the left lung mass, Dr. Caffrey identified anthracotic pigment but no nodules or any definite fibrosis. However, the second set of slides from a left lung biopsy revealed a moderate amount of anthracotic pigment with some fibrosis. In addition, under polarized light he saw some birefringent particles. Dr. Caffrey opined that lesions found by biopsy were compatible with simple CWP.

Narrative Reports

Dr. Randolph Forehand, a B-reader, examined Claimant on December 12, 2002 and submitted a report. (DX 10). Dr. Forehand considered the following: symptomatology (sputum, wheezing, dyspnea, cough, chest pain, orthopnea, and ankle edema), employment history (26 years underground coal mine employment, last working as a roof bolter, and quitting in 1993), individual history (frequent colds, pneumonia, attacks of wheezing, arthritis, heart disease, allergies, diabetes mellitus, and high blood pressure), family history (high blood pressure, heart disease, tuberculosis, cancer, asthma, and allergies), smoking history (never smoked), physical examination (crackles heard at the bases, right greater than left), chest x-ray (1/1), PFT (normal), ABG (hypoxemia with exercise but no metabolic disturbance), and an EKG (no acute changes). Dr. Forehand diagnosed pneumoconiosis based on the x-ray, history, physical examination, and the ABG study. He also diagnosed coronary artery disease by history. Dr. Forehand opined that these conditions were the result of coal dust exposure and atherosclerosis. He added that Claimant had a significant respiratory impairment of a gas-exchange nature, and that insufficient residual oxygen transport status remains for Claimant to return to his last coal mining job. As a result, Dr. Forehand concluded that Claimant was totally and permanently disabled and that pneumoconiosis was the sole factor contributing to his respiratory impairment. Finally, he stated that there was no evidence of congestive heart failure or pulmonary edema which might contribute to the respiratory impairment.

Dr. Donald Rasmussen, an internist, senior disability analyst, and B-reader, examined Claimant on May 5, 2005 and submitted a report. (CX 1). Dr. Rasmussen considered the following: symptomatology (shortness of breath with exertion, orthopnea, ankle swelling, paroxysmal nocturnal dyspnea, chronic fatigue, chest pain, and bloody cough), employment history (23 to 25 years coal mine employment, last working as a roof bolter, which involved

¹¹ Dr. Burki opined that this study was technically acceptable.

heavy to very heavy manual labor, and quitting in 1993), individual history (frequent colds, pneumonia, 1996 myocardial infarction, 2004 CABG and catheterization, hypertension, and masses on his left lung), family history (hypertension, heart disease, tuberculosis, diabetes, cancer, asthma, emphysema, and black lung), smoking history (never smoked), physical examination (no significant findings), chest x-ray (1/2 simple pneumoconiosis and Category A large opacities, which were indeterminate for pneumoconiosis or cancer), PFT (minimal, irreversible restrictive ventilatory impairment), ABG (minimal resting hypoxia), and an EKG (regular sinus rhythm and left bundle branch block pattern). Dr. Rasmussen diagnosed CWP based on exposure to coal mine dust and the x-ray findings. Furthermore, he stated that it was medically reasonable, based on the Category A large opacities, to conclude that Claimant has complicated pneumoconiosis, but he did not exclude the possibility of malignancy. He opined that the lung function studies indicated a marked loss of lung function, and based on these studies, he concluded that Claimant does not retain the pulmonary capacity to perform his last regular coal mine job. Finally, Dr. Rasmussen concluded that the only known cause of Claimant's disabling lung disease is coal dust exposure.

Dr. Paul Wheeler, a radiologist and B-reader, submitted a report dated May 27, 2005, which considered four CT scans conducted in 2004 and 2005. (EX 7). Concerning the December 9, 2004 CT scan, Dr. Wheeler found some small nodules in the upper lobes that could be CWP. Considering the January 31, 2005 scan, Dr. Wheeler stated that this was a limited scan for a lung biopsy, and that it revealed tiny calcified granulomata in nodes in the lower hila and pulmonary vascular congestion or interstitial fibrosis in the posterior lower lobes. He opined that the February 8, 2005 scan showed moderate pulmonary vascular congestion or ARDS slightly increasing in the posterior lower lobes since the last scan. Finally, Dr. Wheeler opined that the March 21, 2005 scan revealed some small nodules mixed with linear and irregular scars in the upper lungs that could be CWP, but he concluded that granulomatous disease would explain all lung findings and is the cause of the 2 cm focally calcified mass in the left and mid lung, the tiny calcified granulomata in the upper lungs and hilar nodes and pleura, and the right apical disease.

Dr. Wheeler was deposed by the Employer on February 15, 2006, when he repeated the findings of his earlier written report. (EX 9). Based on the x-rays he considered, Dr. Wheeler opined that Claimant suffered from granulomatous disease. Next, Dr. Wheeler stated that the December 9, 2004 CT scan included a 2.5 mm thick, high resolution scan, but the January, February, and March 2005 scans were all 5 mm thick or more, which produced a more general-lung scan. Dr. Wheeler opined that all of the evidence he considered points toward granulomatous disease, probably due to histoplasmosis. However, he also concluded that Claimant does have some nodules that could be related to the inhalation of coal mine dust, but that there are no large opacities. Specifically, he stated that it was not possible to identify which of the nodules were due to CWP and which ones were due to intrinsic heart and lung disease. Turning to the two-centimeter mass, Dr. Wheeler assumed that it represented granulomatous disease, but he stated that he would acquiesce if there was a needle biopsy showing it to be a large opacity.

On cross-examination, Dr. Wheeler stated that a radiologist's job is to localize areas of abnormality, but not to make an exact diagnosis. He opined, "And any radiologist who tells you that he can tell the difference between a cancer or a mass that's due to infection on an x-ray

alone is blowing in the winds, because I've seen even tuberculosis masses destroy ribs just exactly the way a lung cancer would." Dr. Wheeler added that the final diagnoses are made either at autopsy or by biopsies or lobectomies.

Dr. David Rosenberg, an internist, pulmonologist, and B-reader, examined Claimant on October 27, 2003 and submitted a report dated January 26, 2006. (EX 1). Dr. Rosenberg considered the following: symptomatology (shortness of breath, cough, and sputum production), employment history (23 years underground coal mine employment, last working as a roof bolter which required lifting up to 60 pounds, and quitting in 1993 due to an injury), individual history (bypass surgery in 1996, allergies, hypertension, diabetes, and pneumonia), family history (myocardial infarction and carcinoma), smoking history (never smoked), physical examination (no significant findings), chest x-ray (0/0), PFT (mild restriction with a definite response to bronchodilator and a normal diffusing capacity when corrected for lung volumes), ABG (chronic metabolic acidosis), EKG (right bundle branch block and left ventricular hypertrophy), CT scans (12/9/04, 12/8/05, 1/31/05, and 3/21/05)¹², and a majority of the evidence in the record prior to the date of this report¹³. Dr. Rosenberg diagnosed COPD based on a reduced FEV1%. He opined that from a functional perspective Claimant's restriction with a low diffusing capacity and a gas exchange abnormality renders him unable to perform his previous coal mining job or similarly arduous type of labor.

Dr. Rosenberg submitted a supplemental report on March 13, 2006. (EX 15). He stated that Dr. Rasmussen's October 27, 2003 evaluation was "superfluous with respect to [Claimant's] overall clinical picture," and that the conclusions from his January 2006 report would be the same if Dr. Rasmussen's 2003 conclusions were removed from his consideration.¹⁴

Dr. Gregory Fino, an internist, pulmonologist, and B-reader, submitted a report dated January 27, 2006. (EX 3). Dr. Fino considered a majority of the evidence in the record prior to the date of this report¹⁵. Dr. Fino found pathologic evidence of simple CWP and some kind of infiltrative interstitial pulmonary process that has resulted in a disabling respiratory impairment

¹² While Dr. Rosenberg's interpretations of these CT scans are not admissible, his review and consideration of Dr. Wheeler's findings are. I note, however, that it is not possible to distinguish which of his findings concerning CWP were based strictly on the admissible evidence alone. Specifically, in dismissing the existence of CWP and complicated pneumoconiosis, Dr. Rosenberg considered the combined CT scan, x-ray, and biopsy evidence. Therefore, I find that Dr. Rosenberg's pneumoconiosis conclusions are inadmissible.

¹³ Dr. Rosenberg considered Dr. Rasmussen's October 28, 2003 medical report. While this report is included in the file, it was explicitly withdrawn from consideration at the hearing. I note, however, since Dr. DePonte's March 19, 2005 x-ray interpretation was excluded from consideration, Dr. Rasmussen's report, in its entirety, would be admissible within the limitations of §725.414. Therefore, while Dr. Rosenberg's consideration of this report is admissible within the limitations, the weight of his conclusions based on this evidence will be diminished due to his consideration of evidence not in evidence.

¹⁴ This supplemental report cures the defects discussed in note 12.

¹⁵ Dr. Fino considered Dr. Rasmussen's October 28, 2003 medical report. Therefore, like Dr. Rosenberg's report, I find that Dr. Fino's consideration of this report is admissible within the limitations, but the weight of his conclusions based on this evidence will be diminished due to his consideration of referenced evidence which was not in evidence. Furthermore, unlike Dr. Rosenberg, Dr. Fino's January 2006 report only considered the CT scan interpretations by Dr. Wheeler and the treating physicians, and thus, his conclusions based on this evidence are admissible.

that has progressed significantly between 2002 and 2005. However, he noted that he could not state an etiology of this impairment or the abnormal chest film interpretations

Dr. Fino was deposed by the Employer on February 13, 2006, when he repeated the findings of his earlier written report. (EX 5). I note, however, that this testimony was based, in large part, on his inadmissible interpretations of the CT scans, and thus, his conclusions based on this evidence are equally inadmissible.

Dr. Fino submitted a supplemental report on April 7, 2006. (EX 16). He stated that his opinion would remain unchanged even if he had not considered Dr. Rasmussen's October 28, 2003 report.¹⁶

Treatment Records

Employer submitted treatment records from Hunting VAMC (EX 10), Buchanan General Hospital (EX 11), Carilion Roanoke Memorial Hospital (EX 12), and Bristol Regional Medical Center (EX 2).¹⁷ The pertinent records are summarized as follows:

October 31, 1998 – X-ray report by Dr. Patel: persistent densities in the bases which may be due to pneumonia or atelectasis. (EX 11).

November 1, 1998 – X-ray report by Dr. Patel: Densities in the lung bases which may be due to atelectasis or pneumonic process. (EX 11).

November 2, 1998 – CT scan report by Dr. Patel: Densities in the lung bases with air bronchograms suggestive of bibasilar pneumonic process. (EX 11).

November 4, 1998 – X-ray report by Dr. Patel: Some improvement of the pneumonic process associated with atelectasis in the lung bases with small bilateral pleural effusions. No other acute pathology. (EX 11).

January 15, 1999 – X-ray report by Dr. Hoffnung: No definite infiltrates are identified. (EX 2).

July 16, 2001 – Progress note by Dr. Patel: Symptomatology (fever, chills, cough with productive sputum), examination (bilateral fair air entry noted). Impression: Fever with chills, possibly from UTI. (EX 11).

¹⁶ This supplemental report cures the defects discussed in note 14 concerning his consideration of Dr. Rasmussen's 2003 report.

¹⁷ Included in the treatment notes are x-ray reports from several physicians. There is no evidence in the record as to the x-ray reading credentials of these physicians. §718.102(c). Also, these interpretations were all related to the treatment of Claimant's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. §718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. §718.102(b). As a result, these x-ray interpretations are not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

July 16, 2001 – X-ray report by Dr. Patel: Increase in the densities in both lung fields, which may be due to difference in technique with possibility of superimposed acute process like pneumonia. (EX 11).

July 27, 2001 – Progress note by Dr. Patel: Still has some shortness of breath and cough, but no significant productive sputum. Lungs reveal bilateral fair entry with occasional rhonchi. Impression: resolving pneumonia. (EX 11).

September 8, 2003 – Examination report by Dr. Patel: Symptomatology (shortness of breath, productive cough, and low grade fever), physical examination (bilateral fair air entry noted with a few scattered rhonchi), and x-ray (shows increased bronchovascular markings). Impression: acute bronchitis. (EX 11).

September 9, 2003 – X-ray report by Dr. Patel: Chronic interstitial changes in the lungs. (EX 11).

May 7, 2004 – X-ray report by Dr. Alkhankan: Diffuse interstitial disease is seen. There is some poorly-defined increased density in the left mid lateral lung and, to a lesser degree, in the right mid lateral lung. An area of infiltrate or mass could not be excluded. CT scan of the chest is recommended. (EX 10).

June 15, 2004 – X-ray report by Dr. Stevenson: Extensive chronic pleural and parenchymal changes. No definite acute disease is seen. Clinical correlation is requested. Further evaluation with CT should be considered if clinically warranted. (EX 10).

July 27, 2004 – X-ray report by Dr. Elbash: Resolving air space disease with probable minimal residual infiltrate in the right mild lung zone. Probable areas of left mid lung zone pleural and parenchymal scarring. (EX 10).

October 18, 2004 – X-ray report by Dr. Shweihat: Ill-defined air space disease in the right mid and right lower lung zones. Possible infiltrates or edema. (EX 10).

December 6, 2004 – X-ray report by Dr. Rajan: Ill-defined right mid and right lower lung zone air space disease of a probable chronic nature. Air space disease left parahilar left mid lung zone, where a large possible non-calcified pulmonary nodule is imaged. This should be further evaluated with PA and left lateral views of the chest in the radiology department. (EX 10).

December 6, 2004 – Discharge summary by Dr. Skeens: Lung nodules seen on CT scan, and moderate restrictive lung disease with moderate decrease in DLCO on PFTs. Ph was low on ABG and appears to be in error as the bicarb remained normal and the findings with PCO₂ were discordant with that. (EX 10).

December 7, 2004 – X-ray report by Dr. Alkhankan: Persisting left parahilar incompletely imaged air space disease. The previously suspected left pulmonary nodule is not confirmed. Persisting right mid and right lower lung zone air space disease, probably chronic rather than acute in nature. (EX 10).

December 9, 2004 – CT scan report by Dr. Skeens: There is extensive disease in the lungs with interstitial changes and areas of nodularity and scarring. There is a well-defined 2.3 cm mass in the left lung, which contains some calcification, but the appearance is not particularly suggestive of a simple calcified granuloma. The possibility of a scar carcinoma cannot be excluded. There are borderline lymph nodes in the mediastinum. (EX 10).

January 13, 2005 – X-ray report by Dr. Williams: There are nonspecific interstitial changes present, but no focal infiltrate or effusion seen. Nodule described on CT is not well-demonstrated on plain film. (EX 10).

January 31, 2005 – CT scan report by Dr. Williams: CT guided needle biopsy was performed, and revealed no immediate pneumothorax. (EX 10).

February 8, 2005 – CT scan report by Dr. Munn: Compared to the December 9, 2004 study, the mass densities in the lateral aspects of the upper lobes and within mass lesion in the lingual are stable in size and character, there is increasing pulmonary vascular congestion and increasing interstitial markings diffusely, the bibasilar ground-glass/alveolar opacities have significantly increased, and stable lymph nodes and stable bilateral pleural thickening are noted. (EX 10).

February 9, 2005 – X-ray report by Dr. King: Bilateral pulmonary parenchymal opacities are unchanged. (EX 10).

March 21, 2005 – CT scan report by Dr. Munn: CT guided needle biopsy was performed, and revealed no immediate pneumothorax. (EX 10).

March 21, 2005 – CT scan report by Dr. Gooding: The pulmonary interstitial markings are increased bilaterally. Nodular opacity is noted in the left mid lung and in the left lower lobe. (EX 10).

March 22, 2005 – Discharge summary by Dr. Bihonege: Patient underwent a CT guided needle biopsy of the left lung mass. (EX 10).

Smoking History

Claimant testified that he has never smoked. (DX 16; Tr. 41). There is no evidence in the record to dispute this finding. Therefore, I find that Claimant has never smoked.

DISCUSSION AND APPLICABLE LAW

This claim was filed after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and
2. Has met the requirements for entitlement to benefits by establishing that he:

- (i) Has pneumoconiosis (see § 718.202), and
 - (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and
 - (iii) Is totally disabled (see § 718.204(c)), and
 - (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and
3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

(a) For the purpose of the Act, “pneumoconiosis” means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or “clinical” pneumoconiosis and statutory, or “legal” pneumoconiosis.

(1) *Clinical Pneumoconiosis*. “Clinical pneumoconiosis” consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis*. “Legal pneumoconiosis” includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For the purposes of this section, a disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). I may also assign heightened weight to the interpretations by physicians with superior radiological qualifications. See *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989). In *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985), however, the Board stated that it “takes official notice that the qualifications of a certified radiologist are at least comparable if not superior to a physician certified as a reader pursuant to 42 C.F.R. §37.51” Finally, if the film quality is “poor” or “unreadable,” then the study may be given little weight. *Gober v. Reading Anthracite Co.*, 12 B.L.R. 1-67 (1988).

The record contains eight interpretations of three chest x-rays, and one quality-only interpretation. Dr. Forehand, a B-reader, and Dr. Alexander, a radiologist and B-reader, interpreted the December 12, 2002 x-ray as positive for pneumoconiosis. Dr. Wiot, also a radiologist and B-reader, read the film as negative. According more weight to the dually credentialed interpretations by Drs. Alexander and Wiot, and noting that they disagree as to the results, I find that the December 12, 2002 x-ray is inconclusive.

Dr. DePonte, a radiologist and B-reader, interpreted the October 27, 2003 film as positive for pneumoconiosis. Dr. DePonte also identified Category A larger opacities. Dr. Rosenberg, a B-reader, and Dr. Wheeler, a radiologist and B-reader, interpreted the film as negative for pneumoconiosis. According more weight to the dually credentialed interpretations by Drs. Wheeler and DePonte, and noting that they disagree as to the results, I find that the October 27, 2003 x-ray is inconclusive for both simple and complicated pneumoconiosis.

Dr. Rasmussen, a B-reader, interpreted the May 5, 2005 x-ray as positive for both simple pneumoconiosis and Category A large opacities. Dr. Wheeler, however, found the film to be negative. Based on Dr. Wheeler’s dually credentialed interpretation, I accord his opinion more weight than that of Dr. Rasmussen. Therefore, I find that the May 5, 2005 x-ray is negative for both simple and complicated pneumoconiosis.

I have determined that the December 12, 2002 and October 27, 2003 films are both inconclusive. I have also found that the most recent film, conducted on May 5, 2005, is negative for the disease. In addition, the record includes two dually credentialed positive readings and three dually credentialed negative readings. Therefore, I find that Claimant has not established the presence of pneumoconiosis by a preponderance of the evidence under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. Dr. Caffrey's biopsy report concluded that Claimant has a moderate amount of anthracotic pigment with some fibrosis. As a result, he opined that the lesions found by biopsy were compatible with simple pneumoconiosis. I find that Dr. Caffrey's opinion is adequately based on the evidence he considered, and is thus, well-reasoned and well-documented. Furthermore, since there is no contrary biopsy evidence of record, I find that Claimant has established the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) It is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also, Mosely v. Peabody Coal Co.*, 769 F.2d 257 (6th Cir. 1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

Based on a positive x-ray interpretation, history, the physical examination, and the ABG, Dr. Forehand concluded that Claimant suffered from pneumoconiosis. While it is clear that Dr. Forehand diagnosed clinical pneumoconiosis, I note that the preponderance of the x-ray evidence does not support such a finding, but that the biopsy evidence does. Furthermore, I note that while the post-exercise ABG was qualifying for total disability, and while his physical examination did reveal potentially significant results, Dr. Forehand did not explain how these findings, in and of themselves, were sufficient to support a finding of pneumoconiosis, either clinical or legal. *See Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis). However, as Dr. Forehand based his diagnosis on the objective evidence before him, and as his clinical pneumoconiosis diagnosis is supported by the pathology findings, I find

that his opinion is adequately well-reasoned, documented, and thus, entitled to probative weight. On the other hand, I find that his failure to provide an explanation as to how the objective results support a finding of legal pneumoconiosis, or to even explicitly state that Claimant suffers from legal pneumoconiosis, diminished the weight of this opinion. Therefore, I accord Dr. Forehand's legal pneumoconiosis diagnosis only some weight.

Dr. Rasmussen considered employment history, the results of a physical examination which produced no significant findings, non-qualifying PFT and ABG studies, and an x-ray interpretation. Based explicitly on his x-ray reading and Claimant's exposure to coal dust, Dr. Rasmussen opined that Claimant suffered from both simple and complicated pneumoconiosis. The Sixth Circuit Court of Appeals has held that merely restating an x-ray is not a reasoned medical judgment under § 718.202(a)(4). *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). The Board has also explained that, when a doctor relies solely on a chest x-ray and coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his opinion "merely a reading of an x-ray . . . and not a reasoned medical opinion." *Taylor v. Brown Bodgett, Inc.*, 8 B.L.R. 1-405 (1985). Furthermore, while Dr. Rasmussen ultimately concluded that Claimant suffered from complicated pneumoconiosis, based on the x-ray, he also stated that the Category A large opacities were indeterminate for pneumoconiosis or cancer. An opinion may be given little weight if it is equivocal or vague. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000). As a result, I find that this "indeterminate" diagnosis is equivocal, and that his narrative diagnoses of both simple and complicated pneumoconiosis are merely restatements of his x-ray reading. Therefore, I accord Dr. Rasmussen's pneumoconiosis diagnoses no weight in my analysis under subsection (a)(4).

Dr. Wheeler considered four CT scans, and concluded that these studies pointed toward granulomatous disease, probably due to histoplasmosis. However, he also stated that some of the nodules "could be related to the inhalation of coal mine dust." Furthermore, he opined that the CT scans showed no large opacities, and thus, no complicated pneumoconiosis. In his deposition, however, Dr. Wheeler added that he was not able to make an exact diagnosis in this case, and that he would acquiesce to any pathology evidence showing that the 2 cm focally calcified mass in the left and mid lung was, in fact, a large opacity. While I find that Dr. Wheeler has generally opined that Claimant has neither simple or complicated pneumoconiosis, due to his multiple "could be" statements, and his admitted inability to make an "exact diagnosis," I find that his conclusion are too equivocal to rule out the existence of either simple or complicated pneumoconiosis, and thus, are entitled to little weight. *See Island Creek Coal Co.*, 202 F.3d 873.

In note 11, above, I determined that Dr. Rosenberg's CWP conclusions were inadmissible because they were inseparably based on of his interpretations of CT scans in excess of the limitations of §725.414. Therefore, I accord his clinical pneumoconiosis diagnosis no weight. Also, Dr. Rosenberg diagnosed COPD based on Claimant's reduced FEV1% but he failed to provide any explanation as to why he excluded coal dust exposure as a cause of this condition. *See Duke, OWCP*, 6 B.L.R. 1-673. As a result, I find that Dr. Rosenberg has failed to provide a reasoned opinion excluding the possibility of legal pneumoconiosis.

Based on Dr. Caffrey's biopsy report, Dr. Fino opined that Claimant suffers from CWP. As this finding is consistent with the objective evidence of record, I find that Dr. Fino's conclusion is well-reasoned and well-documented. Therefore, I accord his clinical pneumoconiosis finding probative weight.

I have determined that the opinions by Drs. Rasmussen and Rosenberg are entitled to no weight, and Dr. Wheeler's opinion is entitled to little weight. On the other hand, I have determined that Drs. Fino and Forehand's diagnoses of clinical pneumoconiosis are well-reasoned and well-documented, and thus, I have accorded them probative weight. As a result, I find that the weight of the medical narrative evidence is positive for the existence of clinical pneumoconiosis under subsection (a)(4).

(4) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.305 is not applicable to claims filed after January 1, 1982. Also, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982.

Section § 718.304 provides an irrebuttable presumption that a miner's total disability was due to pneumoconiosis if such miner suffered from a chronic dust disease of the lung which:

- (a) When diagnosed by chest x-ray (*see* § 718.202 concerning the standards for X-rays and the effect of interpretations of X-rays by physicians) yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C; or
- (b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or
- (c) When diagnosed by means other than those specified in paragraphs (a) and (b) of this section, would be a condition, which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described: *Provided, however,* That any diagnosis made under this paragraph shall accord with acceptable medical procedures.

As stated in the analysis of §718.202 (a)(1) above, the preponderance of the x-ray evidence is negative for simple pneumoconiosis. Likewise, I find that the x-rays are negative for complicated pneumoconiosis. Drs. DePonte and Rasmussen both diagnosed Category A large opacities. Dr. Rasmussen, however, stated that the large opacities he identified were indeterminate for pneumoconiosis or cancer. Thus, I find that this interpretation is not a conclusive finding of complicated pneumoconiosis. On the other hand, while Dr. DePonte's reader of the October 2003 film is more definitive, based on Dr. Wheeler's equally credentialed negative interpretation, I find this film to be inconclusive for complicated pneumoconiosis. Therefore, I find that Claimant has not proven the presence of complicated pneumoconiosis by a preponderance of the evidence under § 718.304 (a).

Next, while the biopsy evidence of record is sufficient to prove the existence of simple pneumoconiosis, based on Dr. Caffrey's reasoned opinion, there is no biopsy evidence

supporting a finding of complicated pneumoconiosis. Therefore, Claimant has not established the existence of complicated pneumoconiosis under § 718.304(b).

Finally, in the above analysis of §718.202 (a)(4), Dr. Rasmussen was the only physician to opine that Claimant suffered from complicated pneumoconiosis. However, as this opinion was both equivocal, and as I found it to be merely a restatement of the x-ray, I accorded it no weight. Therefore, I find that Claimant has not proven that he suffers from complicated pneumoconiosis under § 718.304(c).

Claimant has establish the presence of simple pneumoconiosis under subsection (a)(2) and (4), but he has failed to trigger the irrebuttable presumption of § 718.304 by proving the presence of complicated pneumoconiosis. Furthermore, I find that even without the medical reports considered under subsection (a)(4), the biopsy evidence is, by itself, sufficient to prove the existence of clinical pneumoconiosis. Therefore, I find that Claimant has established that he suffers from simple pneumoconiosis.

Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must also prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). For a miner who suffers from pneumoconiosis and was employed for ten or more years in one or more coal mines, it is presumed that his pneumoconiosis arose out of his coal mine employment. *Id.* As I have found that Claimant has established 20 years of coal mine employment, and as no rebuttal evidence was presented, I find that Claimant's pneumoconiosis arose out of his coal mine employment in accordance with the presumption set forth in § 718.203(b).

Total Disability

To be entitled to benefits under the Act, Claimant must also demonstrate that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

I have determined that Claimant has not established that he suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. There are no PFT values equal to or below those found in Appendix B of Part 718. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718. None of the pre-exercise ABG evidence of record produced values that meet the requirements of the tables found at Appendix C to Part 718. However, the December 2002 post-exercise ABG produced qualifying values. More weight may be accorded to the results of a recent blood gas study over a study that was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993). Even though the only post-exercise study produced qualifying values, I find that since the two most recent ABGs were non-qualifying, including one conducted nearly two and one half years more recently, I find that the preponderance of the ABG evidence is non-qualifying for total pulmonary disability. Therefore, I find that Claimant has not established total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has not established the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment.

In assessing total disability, the administrative law judge is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

Claimant's usual coal mine employment as a general inside coal worker and roof bolter involved working on his knees and in squatting positions, and lifting and carrying as much as 60 pounds. (DX 4).

Dr. Forehand considered the exertional requirements of Claimant's last coal mine employment, the results of a physical examination, a non-qualifying PFT, and a qualifying post-exercise ABG and concluded that Claimant had a significant respiratory impairment of a gas-exchange nature. He opined that Claimant's residual oxygen transport status was insufficient, and as a result, he was totally and permanently disabled from returning to his last coal mining

job. In addition, he stated that there was no evidence that Claimant's heart condition contributed to this impairment. Dr. Forehand's opinion is adequately supported by the objective evidence he considered, and is thus well-reasoned and well-documented. Therefore, I find that his conclusion is entitled to probative weight.

Dr. Rasmussen found that Claimant's non-qualifying PFT revealed a minimal, irreversible ventilatory impairment and that his non-qualifying ABG showed minimal resting hypoxemia. Considering these results in conjunction with the exertional requirements of Claimant's last coal mine employment, which he found to consist of "heavy to very heavy manual labor," Dr. Rasmussen opined that Claimant did not retain the pulmonary capacity to perform his last regular coal mine job. Even though Dr. Rasmussen did not explicitly state how the non-qualifying study values equated to a totally disabling impairment, I do not find his conclusions to be unreasoned. Specifically, despite the fact that Claimant had only a minimal respiratory impairment, since he found the exertional requirements of Claimant's job as a roof bolter to be substantial, I find that Dr. Rasmussen's total disability conclusion is well-reasoned and well-documented. Therefore, bolstered by his credentials as an internist and a senior disability analyst, I accord his opinion probative weight.

Dr. Rosenberg concluded that due to Claimant's low diffusion capacity and his gas exchange abnormality, he was unable to perform his previous coal mining job or similarly arduous labor. I find that this conclusion is sufficiently supported by the objective evidence he considered, and is thus well-reasoned and well-documented. Therefore, bolstered by his advanced credentials as an internist and pulmonologist, I accord his opinion probative weight.

Based on his review of the evidentiary record, Dr. Fino opined that Claimant suffered from a disabling respiratory impairment that has progressed significantly between 2002 and 2005. I find that this opinion is adequately supported by the evidence he considered, and is thus well-reasoned and well-documented. Therefore, bolstered by his credentials as an internist and pulmonologist, I accord his opinion probative weight.

All of the reporting physicians of record offered well-reasoned and well documented opinions that Claimant was totally disable from a pulmonary standpoint. Therefore, as there is no evidence to the contrary, I find that Claimant has proven by a preponderance of the evidence that he is totally disabled under § 718.204(b)(2)(iv).

Claimant has not established that he is totally disabled under subsection (b)(2)(i)-(iii), but has conclusively proven total disability under subsection (b)(2)(iv). Upon weighing all evidence concerning total disability under §718.204 (b)(2), I find that the narrative medical opinions, which were based, in part, on the PFT and ABG evidence, to be the most probative. Therefore, I find that Claimant has established that he is totally disabled from a pulmonary or respiratory standpoint.

Total Disability Due to Pneumoconiosis

The amended regulations at § 718.204(c) contain the standard for determining whether a miner's total disability was caused by a miner's pneumoconiosis. Section 718.204(c)(1)

determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a “substantially contributing cause” of the miner’s totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a “substantially contributing cause” of the miner’s disability if it has a material adverse effect on the miner’s respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner’s impairment was due to pneumoconiosis.

Except as provided by § 718.204(d), the cause or causes of a miner’s total disability shall be established by means of a physician’s documented and reasoned medical report. § 718.204(c)(2). The Sixth Circuit Court of Appeals has stated that pneumoconiosis must be more than a “de minimus or infinitesimal contribution” to the miner’s total disability. *Peabody Coal Co. v. Smith*, 12 F. 3d 504, 506-507 (6th Cir. 1997). The Sixth Circuit has also held that a claimant must affirmatively establish only that his totally disabling respiratory impairment (as found under § 718.204) was due - at least in part – to his pneumoconiosis. *Cf.* 20 C.F.R. 718.203(a); *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner’s impairment is due to his combined dust exposure, coal workers pneumoconiosis as well as his cigarette smoking history is sufficient). More recently, in interpreting the amended provision at § 718.204(c), the Sixth Circuit determined that entitlement is not precluded by “the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal dust.” *Tennessee Consolidated Coal Co. v. Director, OWCP*, 264 F.3d 602 (6th Cir. 2001). A miner “may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition.” *Id.*

I have found that Dr. Forehand’s clinical pneumoconiosis diagnosis and his total disability determinations were entitled to probative weight. Considering Claimant’s length of coal mine employment and his history as a life-long non-smoker, Dr. Forehand also concluded that pneumoconiosis was the sole factor contributing to the respiratory impairment, and that the evidence did not support a finding that Claimant’s heart condition contributed to this impairment. I find that Dr. Forehand’s opinion is sufficiently supported by the objective evidence he considered, and thus, that his etiology determination is well-documented and well-reasoned. Therefore, I accord his finding that Claimant’s total respiratory disability was due to pneumoconiosis is entitled to probative weight.

Dr. Rasmussen concluded that coal dust exposure was the only known cause of Claimant’s total pulmonary disability. However, while I have found his total pulmonary disability diagnosis to be entitled to probative weight, and while Dr. Rasmussen accurate based his opinion on Claimant’s exposure history and the fact that he was a life-long non-smoker, I note that I have not found his pneumoconiosis diagnosis to be well-reasoned and well-documented under §718.202 (a)(4), and I have found the x-ray he considered to be inconclusive for the disease under §718.202(a)(1). As a result, I find that while the record as a whole supports

a finding of clinical pneumoconiosis, Dr. Rasmussen's opinion does not, and is thus insufficiently well-reasoned and documented for the purpose of determining the etiology of Claimant's total pulmonary disability.

Dr. Rosenberg provided a reasoned and probative opinion that Claimant was totally disabled from a pulmonary perspective, but as determined in my analysis under §718.202(a)(4), I have found his conclusion that Claimant does not suffer from pneumoconiosis to be unreasoned. Specifically, Dr. Rosenberg's clinical pneumoconiosis diagnosis is entitled to no weight due to his consideration of excessive CT scan interpretations, and his legal pneumoconiosis diagnosis is entitled to little weight due to his failure to explain why Claimant's COPD was not partially the result of 23 years coal dust exposure in light of the fact that Claimant never smoked. Similarly, I find that Dr. Rosenberg's total disability causation conclusions are equally unreasoned, and thus, entitled to little weight.

Dr. Fino concluded that Claimant suffers from CWP, and that he is totally disabled from a pulmonary perspective, but he did not offer an opinion as to the cause of Claimant's total disability. Specifically, Dr. Fino stated that his disability was caused by "some kind of infiltrative interstitial pulmonary process," and that he "could not state an etiology of this impairment or the abnormal chest film interpretations."¹⁸ As a result, I find that Dr. Fino's opinion is entitled to no weight in my analysis under §718.204(c).

I have found Dr. Forehand's determination that Claimant's total respiratory disability is due, at least in part, to his clinical pneumoconiosis, to be well-reasoned and well-documented. On the other hand, I have found the opinions by Drs. Rasmussen, Rosenberg, and Fino to be insufficient for the purpose of proving or disproving the etiology of Claimant's total pulmonary disability. Therefore, upon weighting all of the opinions of record, I find that the preponderance of the evidence supports a finding of total disability due to pneumoconiosis.

Entitlement

Claimant has established the existence of pneumoconiosis arising out of coal mine employment. He has also proven, by a preponderance of the evidence, that he is totally disabled due to pneumoconiosis. Therefore, I find that Claimant is entitled to benefits under the Act. However, as I cannot determine the month of onset of total disability due to pneumoconiosis, I find that benefits are payable to Claimant beginning with the month in which he filed his application for benefits. *See* § 725.503(b). Therefore, since he filed his application for benefits in November 2002, I find that benefits are payable beginning with that month.

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein, since no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application, with a service sheet showing that service has been made upon all parties,

¹⁸ As discussed in note 14, above, Dr. Fino's conclusions based on his inadmissible CT scan interpretation will not be considered in this adjudication. Therefore, since his ultimate conclusions as to the cause of Claimant's total disability are inseparably tied to these interpretations, they are equally inadmissible.

including Claimant. The parties have 10 days following receipt of any such application within which to file their objections. The Act prohibits the charging of any fee in the absence of such approval. *See* §§ 725.365 and 725.366.

ORDER

IT IS ORDERED that the claim of T.S. for benefits under the Act is hereby GRANTED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).